

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10197 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10152

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun, R.D.</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rising Sun, R.D.</b>		
c. LENGTH OF STAY IN 1b <b>All life</b>			d. STREET ADDRESS <b>1</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Willard</b> Middle <b>Nelson</b> Last <b>Barrow</b>			4. DATE OF DEATH Month <b>9</b> Day <b>1</b> Year <b>19 60</b>		
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>3-9-1887</b>		9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Machine Op.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Randel Barrow</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Devonshire</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>172-05-6946</b>		17. INFORMANT Address <b>Mrs. Estella Barrow, Rising Sun, R.D.2. Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>R.C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>9-4-60</b>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-5-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cem.</b>	
22d. LOCATION (City, town, or country) <b>Lancaster, Pa.</b>		22e. (State) <b>Pa.</b>			
23. FUNERAL DIRECTOR <b>Thomas E. M. Muller</b>		ADDRESS <b>Rising Sun Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10198

## CERTIFICATE OF DEATH

10153

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>New Castle</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Colora</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clifton Park Manor, Wilmington</b> 46X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ewing Nursing Home</b>		d. STREET ADDRESS <b>45 Central Terrace, Apt. #1</b>	
3. NAME OF DECEASED (Type or print) First <b>Maud</b> Middle <b>E.</b> Last <b>Beugless</b>		4. DATE OF DEATH Month <b>September</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11, 1886</b>
9. AGE (In years last birthday) yrs. <b>73</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Chalkley J. Beugless</b>		14. MOTHER'S MAIDEN NAME <b>Anna R. Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. George W. Beeson</b>		Address <b>45 Central Terrace Clifton Park Manor Wilm., Del.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric thrombosis</b> 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Multiple embolic phenomena</b> DUE TO (c) <b>auricular Fibrillation</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/8</b> , 19 <b>60</b> , to <b>9/15</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/15</b> , 19 <b>60</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rising Sun, Md</b> DATE SIGNED <b>9/15/60</b> ACTUAL SIGNATURE <b>Neil Taylor</b> M.D. <b>Rising Sun, Md</b> <b>9/15/60</b> PHYSICIAN'S NAME (Type) <b>Neil Taylor Jr Rising Sun, Md</b> <b>9/15/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-19-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Riverview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wilmington, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward S. Hallow</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 21 '60</b>	
ADDRESS <b>Wilmington, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hallow</b>	

# CERTIFICATE OF DEATH

INVESTIGATION STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1955

1. NAME OF DECEASED George		2. SEX Male		3. AGE 65	
4. RACE Caucasian		5. BIRTH DATE 1890		6. BIRTH PLACE New York	
7. DEATH DATE September 15, 1955		8. DEATH PLACE Home		9. CAUSE OF DEATH Heart Disease	
10. MEDICAL HISTORY Hypertension, Atherosclerosis		11. PRESENT ILLNESS Myocardial Infarction		12. SIGNATURE OF PHYSICIAN Dr. J. H. Smith	
13. SIGNATURE OF WITNESSES John Doe, Jane Doe		14. SIGNATURE OF REGISTRAR John Doe		15. SIGNATURE OF CLERK John Doe	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE VITAL STATISTICS ACT, 1903, AS AMENDED, AND THE PUBLIC HEALTH SERVICE ACT, 1906, AS AMENDED, AND THE VITAL STATISTICS ACT, 1953, AS AMENDED.

10179

## CERTIFICATE OF DEATH

Reg. Dist. No. 10154

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		d. STREET ADDRESS <b>170 Hollingsworth Manor</b>	
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>WILLIAM</b> Last <b>BLACK</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 3, 1937</b>
9. AGE (In years last birthday) <b>23</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elec. Hose &amp; Rubber, Lansing, N. C.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ira T. Black</b>		14. MOTHER'S MAIDEN NAME <b>Martha Woods</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>241-56-3042</b>	
17. INFORMANT <b>Mrs. Barbara H. Black, Elkton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Embryonal carcinoma of the testicle with metastases to the lungs and brain</b> DUE TO <b>metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>14 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 59</b> to <b>Sept. 18 60</b> , that I last saw the deceased alive on <b>Sept. 18 60</b> , and that death occurred at <b>11:15a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b>		ADDRESS (Street, city or town, state) <b>233 E. Main Street</b>	
PHYSICIAN'S NAME (Type) <b>S. RALPH ANDREWS, JR., M.D.</b>		DATE SIGNED <b>9/18/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-20-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Black Family Cemetery Warrensville, N. C.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME Donald M. Pippin</b>		ADDRESS <b>Elkton, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 20 1960</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Pippin</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CENTRAL OFFICE OF RECORDS

1947

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10199

10155

1. PLACE OF DEATH a. COUNTY <b>CECIL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CECIL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PERRY POINT</b>		c. LENGTH OF STAY IN 1b <b>21 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Not known</b>	
3. NAME OF DECEASED (Type or print) First <b>CLIFFORD</b> Middle <b>E.</b> Last <b>BURKINS</b>		4. DATE OF DEATH Month <b>September</b> Day <b>8</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 7, 1902</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer, retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK BURKINS</b>		14. MOTHER'S MAIDEN NAME <b>MARY DAY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-2 221 18 4102</b>	
17. INFORMANT <b>Ernest Burkins (B)</b>		Address <b>230 N. Franklin St., Wilmington, Delaware.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Possible cardiac arrhythmia &amp; or infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic heart disease autonomic generalized cardomegaly.</b> DUE TO (c) <b>Physiologic: Congestive heart failure.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>Unknown</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Subacute bacterial endocarditis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (✓) (this hospital) attended the deceased from <b>August 18, 19 60</b> to <b>September 8, 19 60</b> that (✓) (we) last saw the deceased alive on <b>Sept. 8, 1960</b> , and that death occurred at <b>2:45 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <i>Josefina C. Rodriguez</i>		22b. DATE SIGNED <b>9-8-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOSEFINA C. RODRIGUEZ, M.D.</b>		22d. ADDRESS <b>VAH., Perry Point, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>9-8-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Cherry Hill, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME,</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 15 '60</b>	
ADDRESS <b>Elkton, Maryland</b>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Kneass</i>	

*Donald M. Dee*

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## CERTIFICATE OF DEATH

Reg. Dist. No.

10156

10180

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. STREET ADDRESS <b>Rd #4</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Louise Mae Creswell</b>				4. DATE OF DEATH Month Day Year <b>9 7 1960</b>			
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 5 1925</b>		9. AGE (In years lost birthday) yrs. <b>35</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Newark Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
3. FATHER'S NAME <b>William Bolton</b>				14. MOTHER'S MAIDEN NAME <b>Hazel Ryan.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-----</b>		16. SOCIAL SECURITY NO. <b>-----</b>		INFORMANT <b>George E. Creswell</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>585X</b> DUE TO (b) <b>Cholecystitis</b> DUE TO (c) <b>Cholecystitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 days</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept 1</b> , 19 <b>60</b> , to <b>Sept 7</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Sept 7</b> , 19 <b>60</b> , and that death occurred at <b>8:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Henry V. Davis</b>				ADDRESS (Street, city or town, state) <b>CHESAPEAKE CITY MD</b>			
PHYSICIAN'S NAME (Type) <b>HENRY V. DAVIS</b>				DATE SIGNED <b>9/9/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/11/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cherry Hill Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Walter In Box Jr.</b>				ADDRESS <b>Elkton Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 14 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10150

CERTIFICATE OF DEATH

10150

4-20-1914

10150

Blank certificate form with faint lines and text.

Page 4 of 4  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the funeral director. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10194

CERTIFICATE OF DEATH

Reg. Dist. No.

10157

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Mabel Middle E. Last Demond		4. DATE OF DEATH Month 9 Day 7 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1902
9. AGE (In years lost birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) North East Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Hines		14. MOTHER'S MAIDEN NAME Albertha Lilley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT Ulysses G. Demond 111 North East, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-0 Coronary Occlusion with myocardial infarction DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 min. 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept., 1958, to 7 Sept., 1960, that I last saw the deceased alive on 5 Sept., 1960, and that death occurred at 4 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huebner M.D.		ADDRESS (Street, city or town, state) North East, Md. DATE SIGNED 9 Sept '60	
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-10-1960	22c. NAME OF CEMETERY OR CREMATORY Methodist	22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Md
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE SEP 13 '60 24b. REGISTRAR'S SIGNATURE Charles S. Kraus	

CERTIFICATE OF DEATH

10152

10152

1. PLACE OF DEATH		2. DATE OF DEATH		3. TIME OF DEATH	
AT HOME		JAN 15 1952		10:00 AM	
4. NAME OF DECEASED		5. SEX		6. AGE	
JOHN J. SMITH		MALE		45	
7. RACE		8. OCCUPATION		9. MARITAL STATUS	
WHITE		LABORER		MARRIED	
10. CAUSE OF DEATH		11. PLACE OF BIRTH		12. DATE OF BIRTH	
HEART DISEASE		BALTIMORE, MD		JAN 15 1907	
13. MEDICAL HISTORY		14. PRESENT ILLNESS		15. DATE OF ONSET	
HYPERTENSION		HEART ATTACK		JAN 10 1952	
16. PHYSICIAN'S SIGNATURE		17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES	
[Signature]		[Signature]		[Signature]	
19. PLACE OF INTERMENT		20. NAME OF FUNERAL HOME		21. DATE OF INTERMENT	
CATHOLIC CHURCH		JOHN J. SMITH		JAN 18 1952	
22. SIGNATURE OF REGISTRAR		23. SIGNATURE OF CLERK		24. SIGNATURE OF DECEASED	
[Signature]		[Signature]		[Signature]	

10152

This certificate is to be filled out by the physician or other person who has attended the deceased, or by the coroner or other person who has examined the body, or by the registrar or other person who has received the body for interment. It is to be filled out in duplicate, one copy to be retained by the person who has attended the deceased, and the other copy to be forwarded to the registrar of the county or city in which the deceased resided at the time of death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10181 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10158

FOR STATE HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Elkton</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Union Hospital of Cecil County</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Principio</u> d. STREET ADDRESS <u>X</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wrightson</u> Middle <u>Thomas</u> Last <u>Dill</u>			4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>19 60</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>12/18/1913</u>		9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brick Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Newark, Del.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Wrightson Dill</u>					
14. MOTHER'S MAIDEN NAME <u>Ella Dill</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)					
16. SOCIAL SECURITY NO. <u>222-01-2895</u>		17. INFORMANT Address <u>Mrs. Wrightson T. Dill Principio, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Occute Cornary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>R.C. Dodson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/23/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/27/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Newark Cem.</u>			
22d. LOCATION (City, town, or country) <u>Newark, Delaware</u>		(State) <u>  </u>					
23. FUNERAL DIRECTOR <u>R.T. Jones</u>		ADDRESS <u>Newark, Delaware</u>		24a. REC'D BY REGISTRAR <u>SEP 28 '60</u>			
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		DATE <u>  </u>					

MEDICAL CERTIFICATION





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

FOR STATE  
HEALTH DEPT.

M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
10182 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10159

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE D.C. b. COUNTY	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Union Hospital		d. STREET ADDRESS 2523 14th St. N.W. 47X-3	
3. NAME OF DECEASED (Type or print) Gertrude Dillard		4. DATE OF DEATH 9 22 1960	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME Walter F. Manuel		14. MOTHER'S MAIDEN NAME Lillian Pearson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. =====	
17. INFORMANT James Dillard, 2523 14th St. N.W.		Address Washington, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Acute Hemorrhagic Pancreatitis DUE TO (b) Fatty Liver. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED 9-22-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/60	
22c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem		22d. LOCATION (City, town, or country) Calmar, Maryland	
23. FUNERAL DIRECTOR R. W. Donaldson, Laurel, Md		24a. REC'D BY REGISTRAR DATE SEP 28 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

10139

UNITED STATES DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(M)

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Usual Residence: \_\_\_\_\_

7. Cause of Death: \_\_\_\_\_

8. Date of Death: \_\_\_\_\_

9. Time of Death: \_\_\_\_\_

10. Signature of Medical Examiner: \_\_\_\_\_

11. Signature of Coroner: \_\_\_\_\_

12. Signature of Police Officer: \_\_\_\_\_

13. Signature of Witness: \_\_\_\_\_

14. Signature of Physician: \_\_\_\_\_

15. Signature of Nurse: \_\_\_\_\_

16. Signature of Undertaker: \_\_\_\_\_

17. Signature of Funeral Home: \_\_\_\_\_

18. Signature of Cemetery: \_\_\_\_\_

19. Signature of Burial: \_\_\_\_\_

20. Signature of Interment: \_\_\_\_\_

21. Signature of Reinterment: \_\_\_\_\_

22. Signature of Disposition: \_\_\_\_\_

23. Signature of Final Disposition: \_\_\_\_\_

24. Signature of Final Disposition: \_\_\_\_\_

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100. Signature of Final Disposition: \_\_\_\_\_

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
19200  
CERTIFICATE OF DEATH

10160

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Atlantic</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>18yrs7mos17days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Margate City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>108 N. Pembroke Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KATHRYN</b> Middle <b>E.</b> Last <b>ELDRIDGE</b>				4. DATE OF DEATH Month <b>September</b> Day <b>28</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 5, 1897</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Telephone Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Archibald S. Lambert</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn E. Knox</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-I</b>		17. INFORMANT <b>Mrs. Leoma Steelman (sister)</b>		Address <b>108 N. Pembroke Ave., Margate City, N.J.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> 601X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pyelonephritis</b> (c) <b>Hydronephrosis with renal calculi</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b> <b>Unknown</b> <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis w/Meningo vascular luetic disease.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from <b>Febr. 11, 1942</b> to <b>Sept. 28, 1960</b> , that (we) last saw the deceased alive on <b>Sept. 28, 1960</b> , and that death occurred at <b>1:15 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Albert L. Mooney</b>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <b>Sept. 28, 1960</b>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <b>ALBERT L. MOONEY, M.D.</b>		22d. ADDRESS <b>VA Hospital, Perry Point, Maryland</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>			
23b. DATE THEREOF <b>9/29/1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Laurel Memorial</b>		23d. LOCATION (City, town, or county) <b>Atlantic City, N.J.</b>		23e. REC'D BY REGISTRAR DATE <b>SEP 30 '60</b>	
23f. FUNERAL DIRECTOR'S SIGNATURE <b>AMMINGTON &amp; SON</b>		ADDRESS <b>Havre DeGrace, Maryland</b>		23g. REGISTRAR'S SIGNATURE <b>Arthur S. Knox</b>		23h. DATE	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 10201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10181

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-1. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME  
SM 7/59

<b>1. PLACE OF DEATH</b> a. COUNTY <b>CECIL</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b> c. LENGTH OF STAY IN b <b>2mos.17days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Veterans Administration Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) e. STATE <b>DISTRICT OF COLUMBIA</b> COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> d. STREET ADDRESS <b>729 N. Capitol Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>JAMES</b> Middle <b>(NMI)</b> Last <b>FORD</b>		<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>24</b> Year <b>19 60</b>					
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>November 24, 1893</b>	<b>9. AGE</b> (In years last birthday) <b>66</b> yrs.	<b>IF UNDER 1 YEAR</b> Months <b>66</b> Days <b>00</b>	<b>IF UNDER 24 HRS.</b> Hours <b>00</b> Min. <b>00</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Freight Handler, retired</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Unknown</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Mass.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>James Ford (Deceased)</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Nellie LaRoque</b>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>WW-1 578-07-9680</b>		<b>17. INFORMANT</b> Address (No relatives) <b>VA Hospital, Perry Point, Md. records.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> 539.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Post operative for stricture of the Esophagus.</b> (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
<b>20e. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	<b>(County)</b>	<b>(State)</b>		
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> <b>Accident</b> <input type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <b>R. C. DODSON, M.D.</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>			
<b>EXAMINER'S NAME</b> (Type) <b>R. C. DODSON, M.D.</b>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>Address</b> (Street, city, town, or county) <b>729 N. Capitol Street, Washington, D.C.</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Removal</b>	<b>22b. DATE THEREOF</b> <b>9/29/60</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Unknown</b>		<b>22d. LOCATION OF LAST KNOWN RESIDENCE</b> <b>Washington, D.C.</b>			
<b>23. FUNERAL DIRECTOR</b> <b>Kenneth J. Smith</b>		<b>ADDRESS</b> <b>1000 1st St. N.W. Washington, D.C.</b>		<b>24e. REC'D BY REGISTRAR</b> <b>DATE SEP 30 '60</b>	<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur E. Evans</b>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No.

10162

10183

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>		d. STREET ADDRESS <b>14-X-2</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>J.</b> Middle <b>Earle</b> Last <b>Gilfillan</b>		<b>4. DATE OF DEATH</b> Month <b>September</b> Day <b>12</b> Year <b>1960</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>August, 11, 1887</b>
<b>9. AGE</b> (In years lost birthday) yrs. <b>73</b>		<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	<b>IF UNDER 24 HRS.</b> Hours <b>0</b> Min. <b>0</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Veterinarian</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Doctor</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <b>Penna.</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Joel C. Gilfillan</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Edna Darlington</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes.</b> (If yes, give war or dates of service) <b>W.W. I</b>		<b>16. SOCIAL SECURITY NO.</b> <b>W.W. I</b>	
<b>17. INFORMANT</b> <b>Mrs. Jennie S. Gilfillan,</b>		<b>Address</b> <b>Galena, Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Accident</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Arterio-sclerotic Heart Disease, Nephrosis (in remission)</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 days.</b> <b>years.</b>
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>19</b> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify</b> that I attended the deceased from <b>Mar 15, 1960</b> to <b>Sept 12, 1960</b> , that I last saw the deceased alive on <b>Sept 12, 1960</b> , and that death occurred at <b>4:00</b> M, from the causes and on the date stated above.			
<b>ACTUAL SIGNATURE</b> <b>Wallace Obenshain</b>		<b>ADDRESS</b> (Street, city or town, state) <b>DATE SIGNED</b> <b>14 Sept 60</b>	
<b>PHYSICIAN'S NAME</b> (Type) <b>Wallace Obenshain</b>		<b>Cecilton, Md.</b>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>	<b>22b. DATE THEREOF</b> <b>Sept. 15, 1960</b>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Gracelawn Mem. Park.</b>	<b>22d. LOCATION</b> (City, town, or county) (State) <b>Wilmington, Del.</b>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Edward Fellows, Wilmington, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE SEP 16 '60</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. K...</b>			





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OFFICE OF THE SECRETARY

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
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to FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10196

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1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>48 S. Main St.</b>		d. STREET ADDRESS <b>48 S. Main St.</b>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Albert</b> Last <b>Hohn</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>3</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min. <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Post Master</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. P.O.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Albert Hohn</b>		14. MOTHER'S MAIDEN NAME <b>Cora Brumfield</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Florence J. Hohn, Port Deposit, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>527.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Relapsing Emphysema</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>15 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 10, 1960</b> to <b>Sept 3, 1960</b> , that (I) (we) lost the deceased alive on <b>Sept 2, 1960</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>G.H. Richards Jr.</b>		22b. DATE SIGNED <b>9/3/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>G.H. Richards Jr.</b>		22d. ADDRESS <b>Port Deposit, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-6-1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hopewell Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. A. Patterson &amp; Son</b>		25a. REC'D BY REGISTRAR <b>SEP 6 1960</b>	
ADDRESS <b>Perryville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
10203 CERTIFICATE OF DEATH 10165									
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point			c. LENGTH OF STAY IN 1b 2yrs 2mo 9days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 2V01-4				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital					d. STREET ADDRESS 3815 Park Heights Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Simon Klein					4. DATE OF DEATH Month Day Year Sept 9 1960				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-17-95		9. AGE (In years last birthday) 65-2-25	
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Clerical VA		11. BIRTHPLACE (State or foreign country) Washington, D.C. MASS.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Hyman Klein					14. MOTHER'S MAIDEN NAME Not ascertainable				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I		17. INFORMANT Unknown		202-14 Address 104 Ave Samuel P. Klein (B) Hollis 12, N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease, severe Years DUE TO (c) Arteriosclerosis, generalized, severe Years								INTERVAL BETWEEN ONSET AND DEATH 1 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus and Essential Hypertension								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (x) (this hospital) attended the deceased from 6-30 1958 to 9-9 1960, that (x) (we) last saw the deceased alive on 9-9-1960, and that death occurred at 11:25P from the causes and on the date stated above.									
22a. SIGNATURE Albert L. Mooney, M.D.					22b. DATE SIGNED 9-10-60				
22c. PHYSICIAN'S NAME (Type) Albert Mooney, M.D.					22d. ADDRESS VAH, Perry Point, Md.				
23a. BURIAL, CREMATION, RECOVERY (Specify) Burial & removal			23b. DATE THEREOF 9-11-60		23c. NAME OF CEMETERY OR CREMATORY Arlington National			23d. LOCATION (City, town, or county) (State) Ft. Myers, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE B. DANZANSKY & SONS, Washington, D.C.					25a. REC'D BY REGISTRAR DATE SEP 13 '60		25b. REGISTRAR'S SIGNATURE Charles S. House		

10-55

CERTIFICATE OF DEATH

10553



Good

Married

Spouse and Name

First Name

Married Name (if different from first name)

Place of Birth

Date of Birth (MM-DD-YY)

Sex

Color

Usual Residence

Place of Death

Date of Death

Signature

Physician's Certification

Attending Physician's Name and Address

Physician's Signature

Medical History and Cause of Death

Age

Sex

Color

Albert L. H. H. H.

Albert H. H. H. H.

Final

Signature

Date

Place of Death

Signature

## CERTIFICATE OF DEATH

Reg. Dist. No.

10166

10184

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>21 Elkton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Devine Haven Nursing Home</b>				d. STREET ADDRESS <b>100 Elkton Blvd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>HARRY WINFIELD LEWIS</b>				4. DATE OF DEATH Month Day Year <b>Sept. 26, 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 10, 1872</b>	
9. AGE (In years lost birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Public Service Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles E. Lewis</b>				14. MOTHER'S MAIDEN NAME <b>Martha Maxwell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Mrs. Dewey Patterson, Elkton, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>old age</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug 10</b> , 19 <b>60</b> , to <b>Sept 26</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Sept 26</b> , 19 <b>60</b> , and that death occurred at <b>9:45 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Henry Davis</b> M.D. <b>Chesapeake Md</b>							
PHYSICIAN'S NAME (Type) <b>HENRY V.D. AVIS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-28-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elkton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>PIPPIN FUNERAL HOME Donald H. Lee Elkton, Md.</b>							
24a. RECEIVED BY REGISTRAR <b>SEP 29 1960</b>							
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1918

1918

1918

(M)

Deceased Name: [Illegible]

Age: [Illegible]

Sex: [Illegible]

Marital Status: [Illegible]

Occupation: [Illegible]

Place of Birth: [Illegible]

[Illegible Signature]

[Illegible Text]

1918-19

[Illegible Text]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10185 CERTIFICATE OF DEATH

10167

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Cecil</b> <span style="float: right;"><b>MARYLAND</b></span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Cecil</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>4 wks. 2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Elkton Hospital</b>				d. STREET ADDRESS <b>Barksdale Road. R.F.D.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>Ella</b> <span style="float: right;"><b>H.</b></span> <span style="float: right;"><b>Musser</b></span>				<b>4. DATE OF DEATH</b> Month <b>9</b> Day <b>19</b> Year <b>1960</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>8-18-1878.</b>	
<b>9. AGE</b> (In years last birthday) <b>82</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>8</b> Days <b>2</b>		<b>IF UNDER 24 HRS.</b> Hours <b>19</b> Min. <b>00</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Home Maker</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home Maker</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Pennsylvania</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>							
<b>13. FATHER'S NAME</b> <b>John Rockey</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>No Record</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>INFORMANT</b> <b>Address Delaware.</b> <b>Roy Musser. 20 S. Old Baltimore Pike. Christiana.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractures right hip</b> DUE TO <b>Fall at home</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Fractures left</b> DUE TO <b>Fall at home</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8/20/60</b> <b>8/20/60</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parotitis left</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>See at home</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>See at home</b>			
<b>20c. TIME OF INJURY</b> Month <b>8</b> Day <b>20</b> Year <b>1960</b> Hour <b>9:30</b> a. m. <b>6:30</b> p. m.				<b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>at home</b>	
<b>20f. (City or town)</b> <b>Cecil</b>				<b>(County)</b> <b>Cecil</b>		<b>(State)</b> <b>Md</b>	
<b>21. I certify that I attended the deceased from</b> <b>8/20</b> , 19 <b>60</b> , to <b>9/19</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/19</b> , 19 <b>60</b> , and that death occurred at <b>1:30</b> P.M., from the causes and on the date stated above. <b>ADDRESS</b> (Street, city or town, state) <b>CHESAPEAKE CITY</b> <b>DATE SIGNED</b> <b>9/19/60</b>							
<b>ACTUAL SIGNATURE</b> <b>HENRY V. DAVIS</b>				<b>PHYSICIAN'S NAME</b> (Type) <b>HENRY V. DAVIS</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>9-22-60.</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Cherry Hill Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Cherry Hill Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ralph E. Hicks</b>				<b>ADDRESS</b> <b>Elkton, Md</b>		<b>24a. REC'D BY REGISTRAR</b> <b>SEP 23 1960</b>	
<b>24b. REGISTRAR'S SIGNATURE</b> <b>Charles S. Hume</b>							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



*[Faint, mostly illegible text on a death certificate form. The form includes fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and Place of Death. There are also lines for the signature of the attending physician and the registrar.]*





10186

## CERTIFICATE OF DEATH

Reg. Dist. No. 10168

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Calvin Parsons				4. DATE OF DEATH Month Sept. Day 4 Year 1960			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1894	
9. AGE (In years lost birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Aberdeen Proving Gr.			
11. BIRTHPLACE (State or foreign country) Del Mar, Delaware				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Cal Parsons				14. MOTHER'S MAIDEN NAME Ella Williams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-03-1133			
17. INFORMANT Mrs. Susie Parsons, North East, Maryland.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Prostate</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>157X</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 22, 1960, to Sept 4, 1960, that I last saw the deceased alive on Sept 4, 1960, and that death occurred at 10:50 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>Henry V. Davis</i> M.D. <i>CHESAPEAKE CITY 11/10/60</i> PHYSICIAN'S NAME (Type) HENRY V. DAVIS MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9-7-60		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Baptist Cemetery	
22d. LOCATION (City, town, or county) North East				(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant				ADDRESS North East, Maryland.		24a. REC'D BY REGISTRAR DATE SEP 7 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanks							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10186

CERTIFICATE OF DEATH

10186

Blank certificate form with horizontal lines for text entry.

D

10187

## CERTIFICATE OF DEATH

Reg. Dist. No.

10170

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Galena</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Devine Nursing Home</b>				d. STREET ADDRESS <b>14X-2</b>			
3. NAME OF DECEASED (Type or print) First <b>Mollie</b> Middle <b>E.</b> Last <b>Petticord</b>				4. DATE OF DEATH Month <b>September</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April, 20, 1869</b>		9. AGE (In years last birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis Hayes</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Appleby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Miss, Selma Scotten,</b>		Address <b>Galena, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Neprosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks.</b>  <b>years.</b>  <b>years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Far-advanced senility</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 19 <b>60</b> , to <b>Sept 25</b> , 19 <b>60</b> that I lost saw the deceased olive on <b>Sept 25</b> , 19 <b>60</b> , and that death occurred at <b>6:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Wallace Obenshain, M.D.</b> <b>27 Sept 60</b>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b> <b>Cecilton, Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 28, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Galena Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Galena, Kent Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Fellows,</b>				ADDRESS, <b>Mellington, Md</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 29 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1

TO HOSPITAL: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

1948

CENTRAL OF DEATH

1948

1. Name: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of Birth: [illegible]  
5. Date of Death: [illegible]  
6. Cause of Death: [illegible]  
7. Place of Death: [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]  
11. [illegible]  
12. [illegible]  
13. [illegible]  
14. [illegible]  
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74. [illegible]  
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99. [illegible]  
100. [illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10171

10204

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bainbridge</b> c. LENGTH OF STAY IN b <b>11 hrs 45 min</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Station Hospital, USNTC, Bainbridge, Md.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b> d. STREET ADDRESS <b>203-B Laffey Circle, Manor Heights</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>THOMAS CHARLES PORTER</b>		4. DATE OF DEATH <b>September 15 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-3-59</b>
9. AGE (In years last birthday) <b>1</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>RICHARD WINFIELD PORTER</b>		14. MOTHER'S MAIDEN NAME <b>LINDA MAE LACY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumococcic Meningitis</b> 340.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>35 hr. 45 min.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. C. DODSON</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>R. C. DODSON, M. D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, or other disposal (Specify)	22b. DATE THEREOF <b>9-17-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham Cemetery, Coloma, Md.</b>	22d. LOCATION (City, town, or country) (State)
23. FUNERAL DIRECTOR <b>Lee a. Patterson &amp; Son</b>		ADDRESS <b>Perryville, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 19 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. House</b>	



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## 1020 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10172

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton R.D.</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Elkton R.D.</b> d. STREET ADDRESS <b>Dogwood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Clarence Powers</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>21</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1923</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto Mechanic</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Repairing autos</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Powers</b>		14. MOTHER'S MAIDEN NAME <b>Emma Ball</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>Yes W W 2</b>		16. SOCIAL SECURITY NO. <b>238-30-5342</b>	
17. INFORMANT <b>Mrs. Clarence Powers, Elkton, Md.</b>		Address <b>R.D.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon Monoxide gas poisoning</b> Conditions, if any, which gave rise to immediate cause (b) <b>973.1</b> (c) <b>DUE TO</b> (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Attached hose to exhaust pipe and ran hose into car</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Attached hose to exhaust pipe and ran hose into car</b>	
20c. TIME OF INJURY Month, Day, Year <b>3.30 a.m. 9/21 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Woods</b>		20f. (City or town) (County) (State) <b>Elkton Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R. C. Dodson</b>		DATE SIGNED <b>9/21/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/24/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Cemetery</b>		22d. LOCATION (City, town, or country) (State) <b>Cherry Hill, Cecil, Md.</b>	
23. FUNERAL DIRECTOR <b>Ralph E. Hicks</b>		24a. REC'D BY REGISTRAR <b>OCT 10 '60</b>	
ADDRESS <b>Elkton, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

10173

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. STREET ADDRESS <b>1 Golts Rd.</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Raison</b>				4. DATE OF DEATH Month Day Year <b>Sept 17 19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/29/26</b>	
9. AGE (In years last birthday) <b>34</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Well digger</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>plumbing</b>		11. BIRTHPLACE (State or foreign country) <b>Concord Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Otto Raison</b>				14. MOTHER'S MAIDEN NAME <b>Viola Hinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>W.W.II</b>				16. SOCIAL SECURITY NO. <b>218-20-3519</b>			
INFORMANT <b>Viola Hinson</b>				Address <b>Warwick, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tuberculous meningitis</b> DUE TO <b>002X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Tuberculosis</b> DUE TO (c) <b>9 months</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 11</b> , 1960, to <b>Sept 17</b> , 1960, that I last saw the deceased alive on <b>Sept 17</b> , 1960, and that death occurred at <b>10:30AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Warwick, Md.</b> DATE SIGNED <b>21 Sept</b>							
ACTUAL SIGNATURE <b>Wallace Obenshain</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Wallace Obenshain, M.D.</b>				<b>Cecilton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/24/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bohemia Manor Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bohemia Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edw R Bell</b> ADDRESS <b>909 Poplar St.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	

TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No.

10174

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East		c. LENGTH OF STAY IN 1b 36 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East	
		d. STREET ADDRESS Cecil Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Philip Middle Richard Last Ricards		4. DATE OF DEATH Sept. 16 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1874
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Tea Room Gas Station	
11. BIRTHPLACE (State or foreign country) Bay View, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Philip A. Ricards		14. MOTHER'S MAIDEN NAME Martha Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Philip R. Ricards, North East, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell carcinoma of prostate with metastasis 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15, 1955, to 16 Sept 1960, that I last saw the deceased alive on 15 Sept 1960, and that death occurred at 1:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Klaus H. Huebner M.D.		ADDRESS (Street, city or town, state) North East, Md.	
DATE SIGNED 9/16/60			
PHYSICIAN'S NAME (Type) Klaus H. Huebner M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-20-60	
22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cem.		22d. LOCATION (City, town, or county) North East (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant		ADDRESS North East, Maryland.	
24a. REC'D BY REGISTRAR DATE SEP 21 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	





TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10206  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10175

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 4yrs.5mo.19days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 26th E. Franklin	
3. NAME OF DECEASED (Type or print) First OMAR Middle D. Last ROUZEE		4. DATE OF DEATH Month September Day 29 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept.8,1897
9. AGE (In years lost birthday) 63 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George A. Rouzee (deceased)		14. MOTHER'S MAIDEN NAME Mary E. Fisher (deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. 219-20-4407	
17. INFORMANT Russell Rouzee, Brother, S. Prospect Street		Address: Charlestown, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, retroperitoneal from aortic synthetic graft DUE TO (b) Arteriosclerotic aortic aneurysm DUE TO (c) Arteriosclerosis, generalized CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LOST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Myocardial infarction, posterior wall		INTERVAL BETWEEN ONSET AND DEATH 28 hours unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>XXXXXX</del> attended the deceased from April 10, 1966, to Sept. 29, 1960, and that death occurred at 8:50 pm from the causes and on the date stated above.			
22a. SIGNATURE A. L. Mooney		22b. DATE SIGNED 9-30-60	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10/1/60	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE		25c. DATE OCT 3 '60	

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STATEMENT OF DEBIT

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CERTIFICATE OF DEATH

Reg. Dist. No.

10189

10176

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>54 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hosp.</b>		e. STREET ADDRESS <b>Elk Mills</b>	
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> Middle <b>V.</b> Last <b>Ruth Sr.</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>Cav</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/14/1886</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textiles</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Allen Ruth</b>		14. MOTHER'S MAIDEN NAME <b>Emma IRONS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-8854</b>	
17. INFORMANT <b>Gladys Ruth Ash</b>		Address <b>Elkton Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anemia &amp; Malnutrition</b> DUE TO <b>Intestinal Obstruction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of Stomach</b> DUE TO (c) <b>1 yr.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 9, 1960</b> , to <b>Sept 14, 1960</b> , that I last saw the deceased alive on <b>Sept 14, 1960</b> , and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph S. Lanz</b> M.D.		ADDRESS (Street, city or town, state) <b>225 W Main St</b>	
PHYSICIAN'S NAME (Type) <b>Joseph S. Lanz</b>		DATE SIGNED <b>9/14/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-18-60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Mem. Pk. Nr. Elkton, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald H. Dee</b>		ADDRESS <b>Elkton, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10170

CERTIFICATE OF DEATH

10170

Case

1. Name of deceased

2. Age

3. Sex

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of witness

10. Signature of family

11. Signature of community

12. Signature of church

13. Signature of school

14. Signature of other

15. Signature of

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1  
 FOR STATE  
 HEALTH DEPT.

10177

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN lb <b>1 hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North East</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>H</b> Last <b>Ryan</b>				4. DATE OF DEATH Month <b>9</b> Day <b>15</b> Year <b>19 60</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 28, 1901</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>59</b> Days	IF UNDER 24 HRS. Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House Keeping</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>F.G. Harvey</b>		14. MOTHER'S MAIDEN NAME <b>Laura Grant</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-16-4726</b>		17. INFORMANT <b>Mr. John Ryan, North East, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemiplegia</b> DUE TO <b>334X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				DATE SIGNED <b>9-16-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-18-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist</b>		22d. LOCATION (City, town, or country) (State) <b>North East, Cecil Co., Maryland</b>	
23. FUNERAL DIRECTOR <b>Joseph R. Grant</b> North East, Maryland				24a. REC'D BY REGISTRAR <b>SEP 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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FOR STATE  
DEPT. OF HEALTH



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CERTIFICATE OF DEATH

Reg. Dist. No.

10178

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>W. SCARBOROUGH</u> Last <u></u>				4. DATE OF DEATH Month <u>9</u> Day <u>4</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 24, 1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Paper Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Talbort Scarborough</u>				14. MOTHER'S MAIDEN NAME <u>Jane Witworth</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-01-0808</u>			
INFORMANT <u>John F. Stephens, Elkton, Md. R.D.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CORONARY OCCLUSION/THROMBOSIS</u> DUE TO <u>CORONARY HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Shown?</u> <u>Symptoms?</u> <u>None??</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/4</u> , 19 <u>60</u> , to <u>9/4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>9/4</u> , 19 <u>60</u> , and that death occurred at <u>5:47 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>9/4/60</u>							
ACTUAL SIGNATURE <u>Peter Stavrakis</u> M.D.				PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cherry Hill, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph G. Hicks</u>				ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 13 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>							

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-38

CERTIFICATE OF DEATH

100-38

Blank certificate form with faint lines and text, including fields for name, date, and cause of death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Daisy Smith				4. DATE OF DEATH Month Day Year September 26, 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 23, 1880	
9. AGE (In years lost birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Templeton				14. MOTHER'S MAIDEN NAME Mary Elizabeth Knotts.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Walter Smith, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO (b) Aortic dissection DUE TO (c) Ruptured aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic arthritis multiple INTERVAL BETWEEN ONSET AND DEATH 3 days 3 1/2 months 3 1/2 months							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 9, 1960, to Sept 26, 1960, that I last saw the deceased alive on Sept 26, 1960, and that death occurred at 8:00 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Henry Dvors M.D. Chesapeake City, Md 9/26/60 PHYSICIAN'S NAME (Type) HENRY V. Dvors							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 29, 1960		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery		22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward Fellows, Millington, Md.				24a. REC'D BY REGISTRAR DATE SEP 29 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
10177											
10180											
1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <b>Del.</b> b. COUNTY <b>New Castle</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chesapeake City</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS <b>600 Vandeder Ave.</b>						
3. NAME OF DECEASED (Type or print) <b>Elizabeth</b>					4. DATE OF DEATH <b>9 18 1960</b>						
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-12-1912</b>		9. AGE (In years last birthday) <b>48</b> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>-</b>		
13. FATHER'S NAME <b>no information</b>					14. MOTHER'S MAIDEN NAME <b>no information</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>					16. SOCIAL SECURITY NO. <b>-</b>					17. INFORMANT <b>Diane Tor, 600 Vandeder Ave. Wilmington, Del.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowned</b> <b>850 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Power boat hit by a Tanker in Canal Ches. &amp; Del.</b>						
20c. TIME OF INJURY Month, Day, Year <b>8 18 60</b> Hour <b>8:50</b> a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>						
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Del. and Ches. Cal</b>					20f. (City or town) <b>Chesapeake City Cecil Md.</b> (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>R.C. Dodson</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
					DATE SIGNED <b>9-20-60</b>						
					Address (Street, city, town, or county)						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>9-23-60</b>			22c. NAME OF CEMETERY OR CREMATORY <b>All Saints</b>			22d. LOCATION (City, town, or country) (State) <b>Wilmington New Castle Del</b>		
23. FUNERAL DIRECTOR <b>Joseph R. Grant</b>			ADDRESS <b>North East, Md</b>			24a. REC'D BY REGISTRAR <b>SEP 21 '60</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

10117 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>1. PLACE OF DEATH</b> e. COUNTY <u>CECIL</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESAPEAKE CITY</u> c. LENGTH OF STAY IN b. <u>1 DAY</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) e. STATE <u>DEL.</u> b. COUNTY <u>N. CASTLE</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WILMINGTON</u> d. STREET ADDRESS <u>600 VANDEVER ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JOSEPH</u> Middle <u>A.</u> Last <u>TOR</u>		<b>4. DATE OF DEATH</b> Month <u>SEPT</u> Day <u>18</u> Year <u>1960</u>	
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Nov. 17, 1912</u>
<b>9. AGE</b> (In years last birthday) <u>47</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>STORE</u>	<b>11. BIRTHPLACE</b> (State or foreign country) <u>PENNA</u>
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SALES</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>No INFO</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>No INFO</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT</b> <u>MRS. JAMES PICCIOTTI WILM, DEL.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DROWNING</u> 850X Conditions, if any, which gave rise to immediate cause (b) <u>850X</u> (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input checked="" type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>CRUISER HIT BY OIL TANKER</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour e.m. <u>8:50</u> <u>9-18</u> 19 <u>60</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> et work <input checked="" type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>C+D CANAL</u>		<b>20f. (City or town)</b> (County) (State) <u>CHESAPEAKE CITY, Md.</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>R.C. DODSON</u> M.D.		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>EXAMINER'S NAME</b> (Type) <u>R.C. DODSON</u>		<b>DATE SIGNED</b> <u>SEPT. 20, 1960</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>9-24-60</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>ALL SAINTS</u>		<b>22d. LOCATION</b> (City, town, or country) (State) <u>WILM, DEL.</u>	
<b>23. FUNERAL DIRECTOR</b> <u>PIPPIN FUNERAL HOME</u>		<b>24a. REC'D BY REGISTRAR</b> <u>SEP 26 '60</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Hume</u>			

(M)

(J)

DROWNED

X CRUISER HIT BY OIL TANKER  
X 7:15 PM 1960  
X 140 CANAL CHESAPEAKE CITY, VA.  
X

*Chesapeake*

X

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

10207  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

10182

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Hartford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>9 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>36 Monroe</b>	
3. NAME OF DECEASED (Type or print) First <b>JACK,</b> Middle <b>JOHN (XXX)</b> Last <b>W. WILLIS</b>		4. DATE OF DEATH Month <b>September</b> Day <b>18</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-5-98</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months <b>62</b> Days <b>18</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Months <b>62</b> Days <b>18</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Willis(deceased)</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Morris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I 577-12-4554</b>	
17. INFORMANT <b>Mrs. Elsie Ames, sister, 36 Monroe Street</b>		Address <b>Aberdeen, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Auricular Fibrillation (Clinical)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Central vascular hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b> <b>unknown</b> <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>xx</del> (this hospital) attended the deceased from <b>September 9, 1960</b> to <b>September 18, 1960</b> and that death occurred on <b>September 18, 1960</b> at <b>4:00 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A.L. Mooney</b>		22b. DATE SIGNED <b>9-19-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A.L. MOONEY, Asst. Clinical Pathologist, V.A. Hospital, Perry Point, Md.</b>		22d. ADDRESS <b>Swan Creek, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/21/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Union Methodist Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Swan Creek, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Henry Tarrington &amp; Son, Aberdeen, Md.</b>		25a. REC'D BY REGISTRAR <b>SEP 22 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		25c. DATE <b>SEP 22 '60</b>	

10102

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10183

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			
c. LENGTH OF STAY IN 1b <b>14 hrs.</b>				d. STREET ADDRESS <b>Elkton</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>F. WOOLMAN</b> Last			4. DATE OF DEATH Month <b>Sept.</b> Day <b>11</b> Year <b>1960</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1881</b>	9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Emanuel Major</b>				14. MOTHER'S MAIDEN NAME <b>Emma line Roff</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT Address <b>Mrs. Mildred Cameron, R. D. Elkton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Acute Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchopneumonia</b> DUE TO (c) <b>AKA, Chronic Bronchitis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2-3 hours</b> <b>2-3 days</b> <b>3-4 days?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9/10</b> , 19 <b>60</b> , to <b>9/11/60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>9/11/60</b> , 19 <b>60</b> , and that death occurred at <b>5:45 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 W Main</b> DATE SIGNED <b>9/11/60</b>							
ACTUAL SIGNATURE <b>Peter Stavrakis</b> M.D.				PHYSICIAN'S NAME (Type) <b>PETER STAVRAKIS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9-14-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>	
				22d. LOCATION (City, town, or county) <b>Elkton, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>PIPPIN FUNERAL HOME</b>				ADDRESS <b>Donah/2. Dee Elkton, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 20 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

10193

Local

Local

Local

Local

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